

## PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

Requested SOC date: \_\_\_\_\_ \*Complete form within 15 business days of the start of care date and submit to DMA.

Name \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Prognosis and expectations of specific disease process \_\_\_\_\_

Date of last physician assessment: \_\_\_\_\_

Approximate hours per day of services requested & why \_\_\_\_\_

Date & name of next MD appointment: \_\_\_\_\_

Approximate length of time services required: Weeks/Months. Specify length of time \_\_\_\_\_

Informal Caregivers availability/Training received: \_\_\_\_\_

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### **TECHNOLOGY REQUIREMENTS & NURSING CARE NEEDS**

1. Ventilator dependent: \_\_\_\_\_ YES \_\_\_\_\_ NO Type: \_\_\_\_\_

Hours per day on ventilator \_\_\_\_\_

2. Oxygen: \_\_\_\_\_ YES \_\_\_\_\_ NO Actual liters per minute and hours per day required \_\_\_\_\_

Continuous prescribed rate \_\_\_\_\_ or adjusted daily/ more often. \_\_\_\_\_

Maintain Sats > \_\_\_\_\_ % Frequent need for adjustments and interventions: \_\_\_\_\_

3. Non-ventilator dependent tracheostomy \_\_\_\_\_ YES \_\_\_\_\_ NO Actual Frequency of Suctioning and results: \_\_\_\_\_

4. Enteral (Tube) feedings: Sole source of nutrition \_\_\_\_\_ YES \_\_\_\_\_ NO

Type of nutrition/frequency/Method of receiving: \_\_\_\_\_

5. Licensed Skilled Nursing interventions and frequency: \_\_\_\_\_

6. Medical History: note functional/communication limitations/incontinence: \_\_\_\_\_

7. Family/Home Dynamics that impact the licensed skilled nursing requirements: \_\_\_\_\_

8. What Community Based resources have been utilized to assist the above recipient? \_\_\_\_\_

**"I am in agreement that the individual is medically stable except for acute episodes that Private Duty Nursing can manage."**

Print Physician's name \_\_\_\_\_

Physician's Signature \_\_\_\_\_ DATE \_\_\_\_\_